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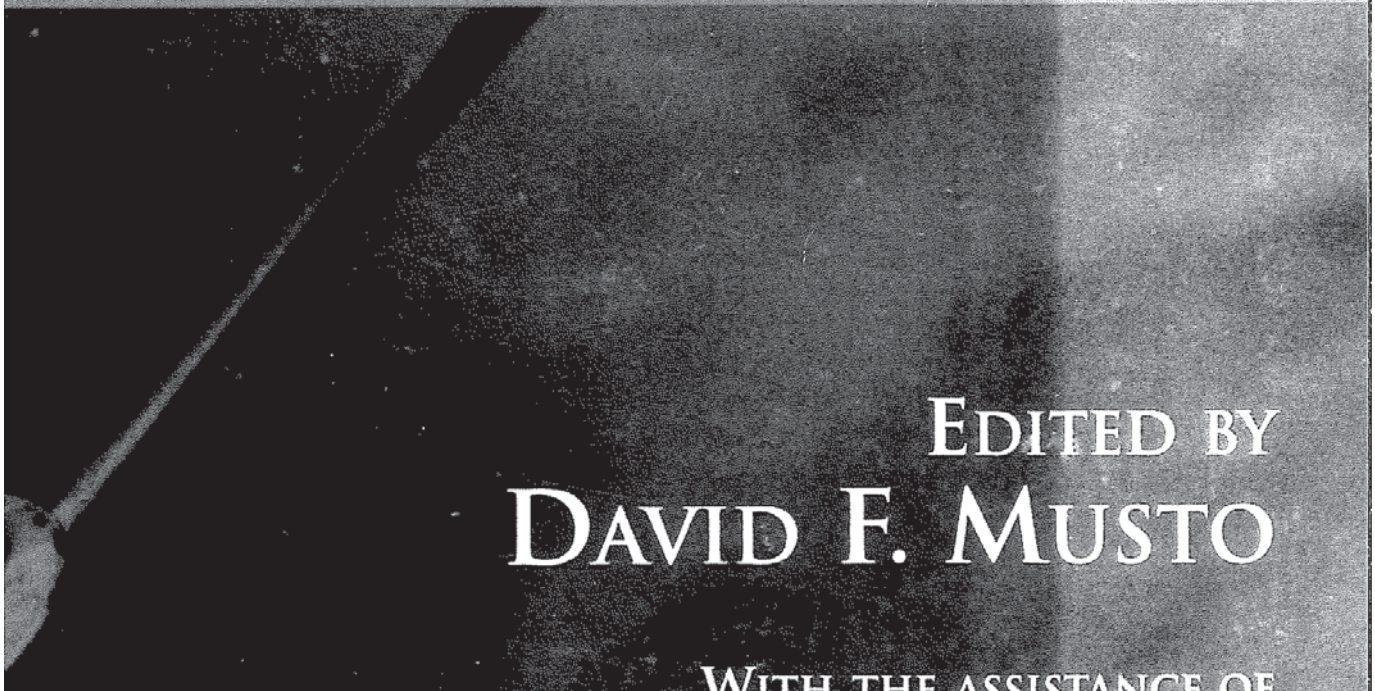
ONE HUNDRED YEARS OF HEROIN



EDITED BY
DAVID F. MUSTO

WITH THE ASSISTANCE OF

One Hundred Years of Heroin

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The Roads to H: The Emergence of the American Heroin Complex, 1898–1956

David T. Courtwright

For some years I have been working on a history of the reception and impact of novel psychoactive drugs. The other day it occurred to me that, at bottom, the story is really a very simple one. It is that of the sorcerer's apprentice. Promising new drugs—aqua vitae, tobacco, morphine, cocaine, barbiturates, amphetamines—are introduced. Therapeutic claims are made and evaluated. Doctors argue among themselves about indications, dosage, and toxicity. The intramural debates seldom attract public notice. But, sooner or later, the new drug slips the bonds of medical discourse and control. It escapes into a larger world of popular pleasure and mischief, prompting official intervention.

The history of heroin in the United States fits neatly into this pattern. In 1898 it was just another promising new product from the Bayer Pharmaceutical Company. In the 1910s it developed a growing underworld following and by the 1920s had become the mainstay of the black market. The federal government outlawed the manufacture of heroin in 1924; as existing stocks dwindled to a few hundred ounces, the drug virtually disappeared from medical practice. The last remaining supplies were swept up by the Narcotic Control Act of 1956, which required the surrender of all remaining pharmaceutical heroin to the federal government. Heroin became, so to speak, America's first Schedule I drug. Its use was totally prohibited except for restricted research purposes, as cannabis, LSD-25, DMT, and mescaline would be in later years. However, the fact that heroin shared the fate of other potent

psychoactive drugs is not an adequate explanation of its prohibition. We need to look more closely at the process of its transformation. We need to understand precisely when, how, and why heroin became H, the top enforcement priority of the Bureau of Narcotics and the basis of an underworld subculture—predominantly white before World War II, and minority thereafter.

MEDICAL USE AND ADDICTION

Heroin use and addiction were originally medical phenomena. What is not generally understood, however, is that the percentage of medical addicts who used heroin was never large. A retrospective study of fifty mostly medical cases published in 1918 showed only two heroin users, or 4 percent of the total (Scheffel 1918, 853–54). Lawrence Kolb, the government's leading medical authority on addiction, carried out a similar study of 150 medical addicts whose use began between 1898 and 1924, that is, after heroin was introduced and before it was effectively outlawed in the United States. The result: two heroin cases, or just 1.3 percent of the total. "My idea has been that the use of heroin in medical practice seldom resulted in addiction," Kolb wrote, "although when used in the underworld for dissipation only it doubtless has produced numerous addicts."[1]

The infrequency of iatrogenic heroin addiction was due to several factors. Heroin, in contrast to morphine and cocaine, was not touted for virtually every physical and medical affliction. Heroin was discussed in the medical literature primarily as a cough suppressant and means of alleviating respiratory distress. It was "recommended chiefly for the treatment of the air passages attended with cough, difficult breathing and spasm, such as different forms of bronchitis, pneumonia, consumption, asthma, whooping cough, laryngitis, and certain forms of hay fever," summed up a 1906 *JAMA* literature review ("Heroin Hydrochloride" 1906, 1303). While some authorities also recommended the drug as an analgesic, this idea was controversial, and early on was challenged by several German and American authorities (for example, Floret 1896, 512; Manges 1898, 770; and Wood 1899, 89–90).[2]

Advertising stressed heroin as a specific for respiratory symptoms. This was true even when heroin was combined with other analgesic products such as Antikamnia, a popular medication whose name means "against pain." The promotional literature for Antikamnia and heroin mentioned several possible indications, but concentrated on glowing clinical reports of cases involving cough and respiratory ailments. The medication came in the form of a tablet consisting of 5 grains of Antikamnia (47 parts acetanilid, 50 parts sodium bicarbonate, and 3 parts tartaric acid) and just 1/12 grain (5 mg) of heroin.[3]

This was typical. When heroin was prescribed for cough and respiratory ailments, it was given in small doses in tablets, pills, pastilles, elixirs, or glycerin solutions. Some preparations contained only 1 or 2 mg per dose (see, e.g., "Herotopine" and "Hermonal," n.d., W. H. Schieffelin and Company Collection). The ingestion of small amounts of an opiate was a good deal safer, from the standpoint of addiction, than hypodermic injection, which was how morphine was often administered.

Death was also a good protection against addiction. Pneumonia and tuberculosis had particularly high mortality rates in the period before antibiotics. Patients with these conditions who were treated with heroin presumably would not have lasted long as addicts, assuming they reached the point of physical dependence.

While some early reports gave assurances that heroin was not habit-forming, and even recommended it as a treatment for morphine addiction, physicians were quickly disabused of these notions. By early 1900 there were several cautionary statements about heroin's toxic and habit-forming potential; by 1903, if not sooner, there were firm and unambiguous declarations with such titles as "The Heroin Habit: Another Curse" (Pettey 1903; see also Wood 1899, 90; Manges 1900, 82; and "Caution Regarding Heroin" 1900, 44).

These warnings about iatrogenic heroin addiction came sooner than comparable warnings about morphine. They were received by physicians who were better educated, more therapeutically conservative, and more mindful of specific treatments for specific diseases than their counterparts of the 1870s and 1880s, when morphine reigned as panacea. In fact, most American (and, ironically, German) doctors in private practice eventually became so wary of heroin that they gave up prescribing it before they were legally required to do so. Government and military physicians had less choice in the matter. The U.S. Public Health Service ceased dispensing heroin in 1916; the army, in 1923; the navy, in 1924 (see "Symposium on 'The Doctor and the Drug Addict'" 1920, 1591; New York State Narcotic Drug Control Commission 1920, 41; Wolff 1932, 2180; and Anslinger 1936).

Now contrast the heroin situation with that of aspirin. Introduced commercially in 1899, the year after heroin, aspirin was Bayer's best-selling drug by 1906 and one of the most widely prescribed drugs in the world by 1914 (McTavish 1987, 104).[4] Not only was aspirin useful in treating a wide variety of conditions, but it was relatively safe and not habit-forming (in the sense of physical dependence). Indeed, I have long believed that one of the reasons for the decline of all forms of iatrogenic opiate addiction in the early twentieth century was the availability of aspirin and kindred preparations to treat rheumatism, colds and flu, toothaches and headaches, and other common aches and pains.

Going further, I believe that degree of exposure is the single most crucial variable in accounting for the prevalence of heroin or any other type of addiction. Yes, set and setting matter; and yes, personality and genetic makeup play a role; and yes, social integration and cultural norms can militate against abuse; and yes, only a minority of those exposed to a given drug typically end up as full-blown addicts. The simple fact remains, however, that those who are never exposed to a drug will never become addicted, and those who are seldom exposed are at much lower risk than those frequently exposed. Aspirin reduced the odds that millions of people from all walks of life who were suffering from common afflictions would come into contact, through either prescription or self-medication, with powerful opiates like morphine or heroin. The net effect was less opiate addiction.

NONMEDICAL USE AND ADDICTION

How, then, were nonmedical users exposed? No simple answer is possible here. In the underworld, many roads led to H. One story has it that prisoners in a state penitentiary were given heroin for cough. News spread among the inmates that the cough pills were "good dope." Word spread outside the prison, and eventually to tenderloins all over the country (Kane et al. 1917, 503).[5] The story is plausible except in one detail. It seems more likely that word of heroin's psychoactive potency spread from multiple sites, rather than one particular prison.

We know that nonmedical heroin addiction was definitely in play by 1910, the year when Leroy Street, pseudonymous author of *I Was a Drug Addict*, and his teenage friends first started sniffing the drug (Street 1953, 11).[6] We also know that many of the early nonmedical heroin users—mostly sniffers—had previously used other drugs, notably opium, cocaine, and tobacco cigarettes.

Police pressure and a national import ban (enacted 1909) had made opium smoking riskier and more expensive. Heroin sniffing was cheaper, quicker, and much harder to detect. By 1916 several reports described opium smokers who had expediently switched to heroin (see, e.g., Bailey 1916, 314; and McIver and Price 1916, 477, 478). Something similar happened with cocaine. The illicit market for cocaine existed well before passage of the 1914 Harrison Narcotic Act. It was created by a combination of informal professional controls—druggists wouldn't sell cocaine to just anybody—and proliferating legal controls of varying stringency (Spillane 2000). The result was an illicit market and higher prices. Decks of cocaine retailed on the streets of New York City for 25 cents, but contained only 1.3 grains (< 85 mg), making the actual price eleven times that of the legitimate wholesale price (Musto 1990, 322–23).

Heroin, by contrast, was cheaper and more readily available from druggists. "Dope users have turned to [heroin]," Boston reformers complained in 1912, "and as the drug is not so well known we find apothecaries who would not sell cocaine who are selling heroin apparently quite freely" (Chase et al. 1912, 9; see also Towns 1916, 221). Heroin was taken in the accustomed form, sniffing; didn't require injection; and had the added advantage of alleviating unpleasant symptoms, such as depression, that might be experienced when quitting cocaine. In 1923 Lawrence Kolb began a systematic study of 230 cases of narcotic addiction, including 40 heroin addicts. His records show that twenty-six of the forty heroin cases used cocaine prior to or concurrently with their first use of heroin (Kolb Papers, Box 6; Courtwright 1982, 161–62 n. 9; see also Stokes 1918, 756–57; Farr 1915, 893–94).

Not all of the heroin sniffers were veteran opium or cocaine users. Another type was the teenage working-class boy, often of immigrant parents, who lived in a "dirty, noisy, cheap, and tough" neighborhood (Stokes 1918, 757). He began using heroin out of curiosity or peer pressure after he had been introduced by someone in his "gang"—more like a younger, scruffier version of the Bowery Boys than the Crips or the Bloods. If he took any other drug on a regular basis, it was tobacco. No observation about the first generation of nonmedical heroin addicts is more commonplace than that they were inveterate cigarette smokers (e.g., Blanchard 1913, 142; and Stokes 1918: 756).

Is there a connection? The chronology, geography, and sociology are all suggestive. Cigarette use was exploding at the same time nonmedical heroin use was taking off. New York City, the center of heroin use, was also the center of the cigarette revolution. In 1910 the city accounted for 25 percent of all U.S. cigarette sales, despite having only about 5 percent of the U.S. population. Cigarettes were particularly popular with New York's immigrants—and many heroin addicts, though born in the United States, came from immigrant families.[7]

Theories developed. R. M. Blanchard, an army doctor, speculated that inhaling smoke increased the absorption of heroin (Blanchard 1913, 142). Harvey Wiley argued that the boy who acquired the cigarette habit would be "brought into sympathetic association with boys who are going to the bad" and that, among other things, he would "more readily become a victim of alcohol, cocain [*sic*], opium, and other narcotic drugs"—an early version of the gateway theory.[8] The addiction specialist Charles Towns likewise argued that cigarettes to alcohol to opiates was a natural progression, both because smokers developed a need for stimulation and because they ran with bad companions (Towns 1916, 152–53, 167, 172).[9] It is hard to know how much weight to assign cigarettes in the etiology equation, but it is at least plausible that their growing use—even more a symbol of defiance and deviance

in 1910 than today—by groups of teenage boys paved the way for heroin experimentation.

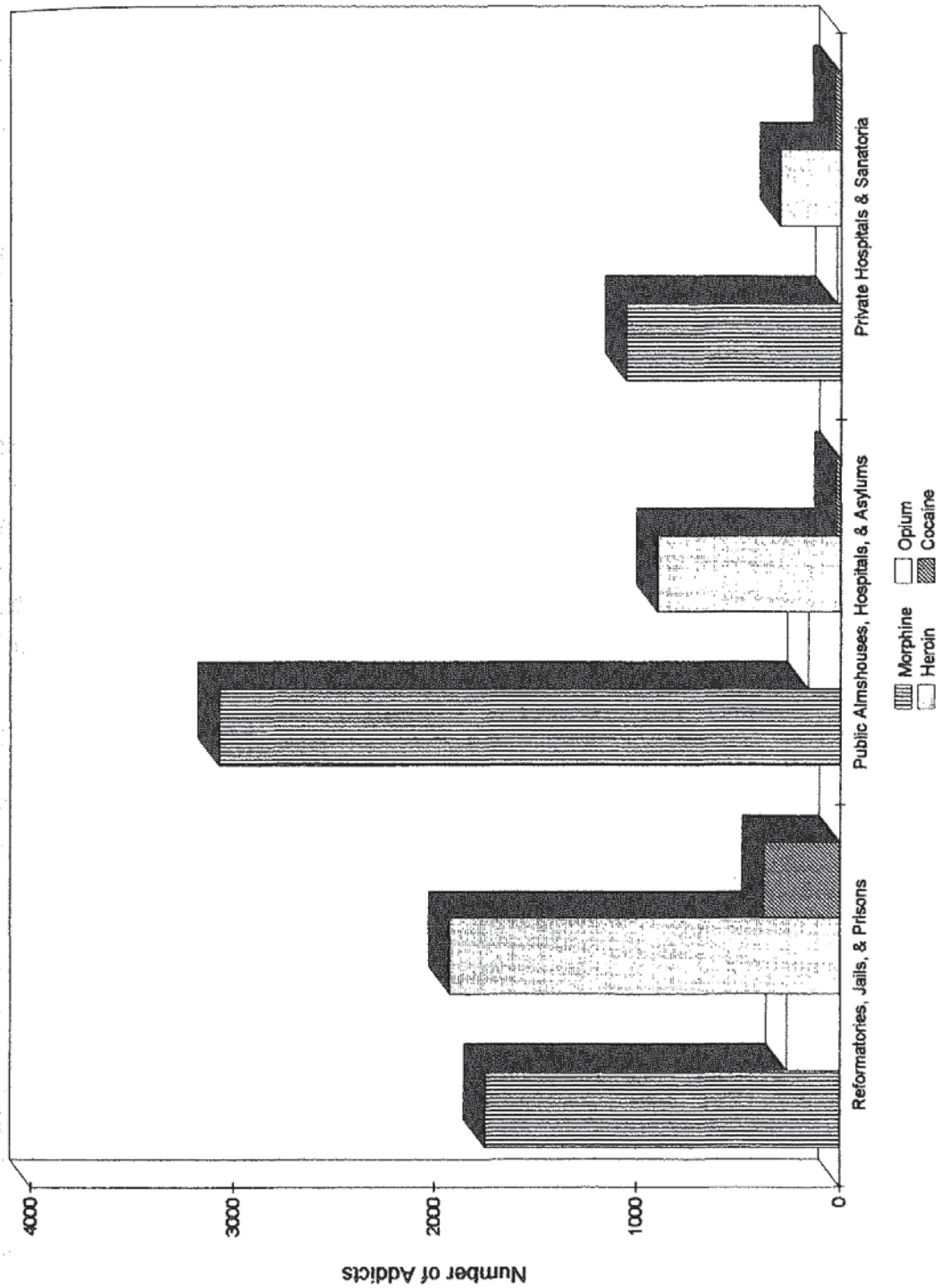
HEROIN OUTLAWED

The emerging stereotype of the heroin addict was far more frightening than that of the old-fashioned morphine addict. Heroin addicts were boys and young men who ruined themselves in the prime of life. Morphine addicts were older and sicker and more often female. Heroin addiction was a vice. Morphine addiction had often originated in response to pain or chronic disease. Heroin addicts were dumb, greedy for drugs, visible, and rude, "members of gangs who congregate on street corners particularly at night, and make insulting remarks to people who pass." Morphine addicts were "more intelligent, secretive as to their habit, and usually temperate in the dosage of their drug" (Leahy 1915, 256; Stokes 1918, 757). Heroin addicts came from the lower and "criminal" classes of the big cities. Morphine addicts came from more diverse and, on the whole, better social backgrounds. The data in figure 1.1, based on Treasury Department questionnaires, show where nearly ten thousand addicts were institutionalized during the period 1916–1918 (U.S. Treasury Department 1919, 15–19). Heroin addicts were more numerous than morphine addicts in jails and prisons, while morphine addicts were far more numerous than heroin addicts in private hospitals and sanatoria. Unsurprisingly, opium smokers and cocaine addicts were also concentrated in penal or public institutions.

Subsequent studies showed a similar pattern. Of 632 convicted male addicts judged suitable for custodial treatment at New York City's Correction Hospital from March 1927 to June 1928, 588 (93 percent) used heroin alone or in combination with other drugs. Of 200 female addicts, 168 (84 percent) did likewise. Though straight morphine addicts were still common in the South in the late 1920s, they were increasingly rare in the North, particularly in correctional settings (Tuttle n.d.).

Why were so many heroin addicts behind bars? In objective terms, the answers are plain enough: because they stole or dealt drugs to support their habits; because they were reared in the slums; because they were single males in their teens and twenties, "prime time" for crime with or without drugs. But inventive propagandists like Richmond P. Hobson gave another answer: because of the action of heroin itself. It "exalted the ego," he testified, making the addict "suited for daring crimes, holdups, robberies, and such crimes as bandits of old never dared" (U.S. Senate, Committee on Printing 1924, 17).[10] Even if heroin addicts did not commit crimes, they were dangerous because of their tendency to proselytize (Bailey 1916, 315). "He has a mania to see others become addicts," said Hobson, who quoted with approval a

Figure 1.1
Institutionalized Addicts, 1916–1918 (9,822 Cases available to Treasury Dept.)



comparison between heroin addiction and leprosy (U.S. Senate, Committee on Printing 1924, 16–17). The metaphor stuck.

Those who have lived through the mid-to-late 1980s do not need to be reminded what happens when the public associates addictive drugs with crime sprees by slum dwellers. In 1920 the AMA's House of Delegates passed a resolution that heroin be eliminated from all medicines and that its importation, manufacture, and sale be banned in the United States. The measure was endorsed by police and penal authorities, and ultimately by Congress, which forbade the importation of opium to manufacture heroin in 1924. Stephen G. Porter, the bill's sponsor, hoped that other nations would emulate America's heroin ban, making it more difficult to divert the drug into the illicit traffic ("History of Heroin" 1953, 7; "Heroin and the International Conferences" 1953, 55–58; Musto 1987 [1973], 200–02).[11]

THE HEROIN COMPLEX

Yet within ten years of its prohibition, heroin was the mainstay of the illicit traffic practically everywhere in the United States. In the mid-to-late 1910s most heroin addicts lived (and died) in the New York–Philadelphia area. That was where most of the large heroin manufacturing and distribution companies were located and where diversion was therefore easiest, as when the American Drug Syndicate Company's Long Island plant was robbed of 150 pounds of heroin tablets in 1920. In other parts of the country, morphine or morphine-and-cocaine addicts were the norm (Courtwright 1982, 101–02; Jonnes 1996, 77).

By the end of 1920 the government had forbidden maintenance and had closed almost all of the municipal narcotic clinics. Some of the displaced patients were able to find doctors willing to write prescriptions. Those who suffered from chronic diseases like advanced tuberculosis, sympathetic figures in the eyes of both physicians and narcotic agents, had the most success in securing a continuous legal supply. But those who were "merely" addicted to narcotics—including virtually all heroin users—generally had to turn to the black market. Most black-market drugs were diverted from legitimate pharmaceutical manufacturers, who were making far more drugs than medically necessary during the 1920s. Enforcement of the Jones-Miller Act (1922) and a series of diplomatic agreements, culminating in the 1931 Limitation Convention to regulate international manufacturing, made diversion more difficult and brought licit production more into line with medical and scientific needs. Supplying the U.S. black market increasingly became a matter of smuggling and then distributing narcotics illicitly manufactured in such distant places as Turkey, the Balkans, and Shanghai.[12]

Heroin was the smuggler's drug par excellence. It was compact and potent, and did not spoil. It could be, and was, adulterated after arrival to increase profits. Even discounting for the adulteration, it was "cheaper for the amount of kick in it" (Helbrant 1941, 30).[13] Neophytes, wary of the needle, could sniff the drug. They could also afford it. Decks of adulterated heroin sold for as little as 50 cents apiece in Harlem during the Depression (Courtwright et al. 1989, 105).[14] These advantages made heroin the primary black-market narcotic throughout the United States, in fact throughout most of the world, by the mid-twentieth century ("History of Heroin," 7; D'Erlanger 1936, 94–95).

Not all addicts approved of the trend. American opium smokers, who regarded heroin as dangerous and declassé, were especially upset. They would have continued as before, but their accustomed drug was becoming progressively scarcer and more expensive. They were victims of what the physician and anthropologist Joseph Westermeyer calls the pro-heroin effects of anti-opium laws. The rigorous enforcement of drug prohibition inevitably drives traffickers and users away from bulkier and more perishable narcotics like opium and toward heroin, with generally evil consequences (Westermeyer 1976, 1135–39).

Let me invoke the work of two other distinguished anthropologists, Vera Rubin and Lambros Comitas. They coined the phrase "ganja complex" to describe a particular pattern of chronic working-class cannabis use in Jamaica and other cultures (Rubin and Comitas 1975, ch. 4; Rubin 1975, 5–6). It seems to me that what had evolved in America by the 1930s was a distinctive "heroin complex." Its attributes can be summarized briefly. Most addicted users were male, poorly educated, irreligious, engaged in part- or full-time hustling; most lived in cities—about half in New York. Many female addicts were prostitutes. Initiated by sniffing, addicts switched to skin popping and mainlining to maximize the effect of adulterated heroin. They suffered high rates of morbidity, mortality, incarceration, and violence tied to disputes over drugs and money. They were part of a deviant, stratified subculture that revolved around the acquisition and use of heroin, had its own specialized language, and was at once mutually supportive and exploitative. "Never trust a junkie" was more than a prejudice of the straight world.

What happened to the heroin complex? Before World War II it was mostly white and, as social problems go, of modest significance. Harry Anslinger, longtime head of the Bureau of Narcotics, estimated that there were thirty-five thousand to fifty thousand nonmedical addicts in the country in 1938 (Anslinger 1938). By contrast, Joseph Greenwood, a Drug Enforcement Administration epidemiologist, estimated that there were 504,000 to 578,000 addicts (that is, a 95 percent confidence interval around an estimate of 546,000) in 1975 (Greenwood n.d.). Bearing in mind the critical things I and

others have said about official prevalence estimates, there is still no question that the heroin complex of the 1930s was small-time compared with that of the 1970s or, for that matter, of the 1990s.

But before the heroin complex got larger, it got smaller. Addiction hit a record low during World War II. The country was prosperous. There was a sense of national purpose. Jobs were abundant and wages were high. Millions of susceptible youths joined the armed forces. There they might acquire the vices of smoking, drinking, and swearing, but not heroin using, at least not in the 1940s (Burnham 1993, 70–71, 101, 220–21). Back on the streets, prices were high and so was adulteration; black-market heroin was often only 1 percent pure by 1944, when it could be found at all.[15] Addicts had to boil down paregoric, eat *yen-shee* (the residue from smoking opium), bribe physicians, forge prescriptions, rob drugstores, switch to other drugs (such as barbiturates), or just plain quit (see Courtwright et al. 1989, 89, 107–08, 131, 168, 193–94, 268; "What's Cooking?" 1945, 99–100; U.S. Treasury Dept., Bureau of Narcotics 1945, 17; "History of Heroin," 8; and Maisel 1945). Some evidently stayed clean for the duration. Voluntary commitments of drug addicts in New York City, the nation's erstwhile heroin capital, dipped to almost zero by 1943 (Rosenthal 1951).

Heroin receded from the national consciousness during and immediately after the war. "In 1947 I was as innocent about drugs as I was about sex . . . ," William Styron wrote in his quasi-autobiographical *Sophie's Choice*. "Our present-day drug culture had not seen, that year, even the glimmerings of dawn, and my notion of addiction (if I had ever really thought of such a thing) was connected with the idea of 'dope fiends'—goggle-eyed madmen in straight jackets immured in backwater asylums, slavering molesters of children, zombies stalking the back streets of Chicago, comatose Chinese in their smoky dens, and so on. There was the taint about drugs of the irredeemably depraved, almost as evil as certain images of sexual intercourse—which until I was almost thirteen I visualized as a brutish act committed in secrecy upon dyed blondes by huge drunken unshaven ex-convicts with their shoes on. As for drugs, certainly I knew nothing about the types and subtle gradations of these substances" (Styron 1979, 311).

But then, in the late 1940s and early 1950s, the narcotic problem became more visible as the flow of smuggled heroin resumed (Jonnes 1996, chs. 8–10). The rituals of postwar addicts, the heroin complex, remained much the same. But their background was changing. They were now younger and darker-skinned. Just how many teenage addicts there were in the 1950s was much disputed. One of the more comprehensive studies, of newly reported addicts in New York State from 1952 to 1958, showed that about 19 percent were under twenty-one and just 5 percent under eighteen years of age (Schlesinger et al. 1959, 4389). Still, any teenage addiction was alarming,

particularly in the apprehensive Cold War climate of the 1950s (see Campbell 2000).

Latino and, especially, black narcotic use was up sharply in the late 1940s and 1950s. From 1935 to 1947 only about 10 percent, on average, of those admitted to the Lexington and Fort Worth hospitals were black. By the mid-1950s the figure had risen to over 40 percent. "I saw a shift in the population," recalled one veteran of Lexington, who was readmitted in 1956. "They came mostly from Chicago and New York, the big cities. They used to say, 'Well, here comes a bunch on the chain from D.C.'—there were a lot of blacks from D.C. If you were arrested and brought there you were hooked up and chained, handcuffed to one another" (Courtwright et al. 1989, 15, quotation at 307).

Explanations for this dramatic development are various and politically sensitive. Some still cling to the "Godfather" conspiracy theory: the Mob decided to dump drugs in black neighborhoods. More plausible is Jill Jonnes's hepster role-model theory. When word got out that the coolest of the cool—black jazzmen like Charlie Parker—used heroin, scores of imitators, "conscientious objectors to the American Dream that never included them," quickly followed (Jonnes 1996, ch. 7, quotation at 121). This began a chain reaction. Older users initiated younger ones, who looked up to them. Dealers became admired figures. Bumpy Johnson, who dealt kilos and drove a Cadillac, was an "idol" to the author Claude Brown's generation, as were "other less well-known, neighborhood racketeers" (Brean 1951, 119; Brown 1984, 54). Brown, of course, grew up in Harlem. Underlying all of this was the shift of black population from the rural South, where heroin was practically nonexistent, to the crowded urban slums, where the traffic was well established. Exposure matters.

The postwar revival of the heroin traffic, the involvement of organized crime (and, according to Anslinger, Communist China), the perceived spread of addiction among teenagers, and the very real spread of addiction in the barrios and ghettos contributed to a further hardening of narcotic policy. The outstanding feature of the 1951 Boggs Act, the 1956 Narcotic Control Act, and analogous state legislation ("Little Boggs Laws") was increasingly stiff mandatory minimum sentences. The 1956 statute even permitted juries to recommend the death penalty for those convicted of sales to minors, an indication of the symbolic importance of the endangered-youth issue.[16]

HEROIN AS THE CENTERPIECE OF AMERICA'S DRUG WARS

The events that followed 1956 properly belong to other contributors to this volume. I would, however, like to make one general observation about

heroin's first century. Like any psychoactive drug that escapes the realm of healing for that of self-indulgence, heroin provoked a legislative response. What set heroin apart was the strength and persistence of that response.

By my count there were five, or perhaps four and a half, federal drug wars in the twentieth century. Heroin figured prominently in three of them. The first, longest, and most significant lasted from 1909 to about 1924. Driven by concerns about heroin and other narcotics, it resulted in the de facto criminalization of nonmedical addiction. The postwar expansion of the inner-city heroin complex triggered another major campaign in the 1950s, engineered by the Bureau of Narcotics and its congressional allies. Yet another heroin epidemic in the late 1960s gave rise to Nixon's drug war, a more enlightened and flexible undertaking than either its predecessors or its successor. Heroin was missing in action only in the marijuana skirmish of the mid-1930s and the Reagan-era drug war. The latter grew out of the increased use of marijuana and cocaine, especially in the form of crack. Though crack eclipsed heroin as drug enemy number one in the late 1980s, heroin made a slow but steady comeback during the 1990s, when increasing supplies and unprecedented levels of street purity provoked new concern. Once again, cocaine users, burned out and jittery, began turning to heroin, just as they had earlier in the century. While it seems unlikely that heroin will again completely supplant cocaine, as it did during the 1920s and 1930s, or will recover the black-market prominence that it enjoyed during the 1950s and 1960s, its suppression remains a critical object of American drug policy.

NOTES

1. "Questionaire [*sic*] re Drug Habit," Box 6, and Kolb to John Remig, 14 November 1927, Box 4, Kolb Papers. This was an almost universal judgment by the 1920s. William White, an authority on treatment history, adds that early twentieth-century proprietary drug cures of the mail-order variety almost never mentioned heroin in their advertising (personal communication).

2. The authoritative *Merck's 1907 Index* refers only to heroin's use as a "cough-sedative" and antispasmodic, recommended in cases of phthisis (tuberculosis), bronchitis, asthma, and so forth. For further discussion of the controversy surrounding heroin's use as an analgesic, see Courtwright 1982, 93. For more on early warnings, see Musto 1974, 176.

3. See the Heroin and Antikamnia brochures in the Antikamnia Chemical Company Collection. Similar items can be found in the Charles L. Mitchell Company Collection and the Lehn and Fink Collection. I am grateful to Charles Greifenstein for calling this material to my attention. See also Fiedler 1979, 59–72; and Haussmann 1891, 181–82.

4. Another interesting case involves Bromo-Seltzer, an over-the-counter preparation consisting of acetanilid, bromide, caffeine, and citric salts. In the 1930s

several deaths were attributed to the product, much to the discomfiture of its manufacturers and advertisers. It turned out, however, that the victims were using Bromo-Seltzer as an analgesic to cope with headaches and other painful symptoms arising from chronic diseases that were the real causes of their demise. Fifty years earlier, they probably would have been using opiates. (See J. Walter Thompson Archives, Forum Series, Emerson Drug Company, January 12, 1937.)

5. Leroy Street tells a version of the story in which the first users were Chinese "hopheads" arrested sometime during or after 1909 for attempting to secure smoking opium in defiance of the national import ban. "A lot of them had a bad cough; when they were in jail they gave them heroin, which is a *marvelous* cure for a cough. But aside from that, it's a hell of an addictive drug" (Courtwright et al. 1989, 289).

6. The date of the first heroin addiction case admitted to Bellevue also was 1910 (Bloedorn 1917, 312). In 1911 Harlow Brooks and H. R. Mixwell noted that "the habit is by no means infrequent especially on the extreme east and west sides of [New York City]" (Brooks and Mixwell 1911, 386). In short, all available historical evidence suggests that nonmedical heroin use took hold in New York City during or just before 1910 and expanded rapidly thereafter. The number of Bellevue heroin cases went from 1 in 1910 to 649 in 1916 (Bloedorn 1917, 312).

7. For national cigarette production figures, see Brecher et al. 1972, 230. For New York consumption, see Kluger 1996, 62. A study conducted by Sylvester Leahy showed a preponderance of children of immigrants (n = 58) over children of native-born parents (n = 53) among heroin addicts (Leahy 1915, 260).

8. Wiley 1917, 150. I am grateful to H. Wayne Morgan for calling this source to my attention.

9. The idea that tobacco leads to drunkenness and other vices has a long history. See, for example, Short 1750, 250; Rush 1798, 270; and Grimshaw 1853, 27–28.

10. Lawrence Kolb, the man fated to deal with America's narcotic obsessives, thought that these views couldn't be crazier. He diplomatically said so in his testimony at the same hearings (U. S. Senate, Committee on Printing 1924, 26–27). Nevertheless, the direct heroin-crime link pushed by Hobson and others affected public perception.

11. For a critical account of Porter's subsequent diplomatic maneuverings, see McAllister 2000, ch. 3.

12. Meyer and Parssinen (1998, chs. 1, 9) offer a comprehensive overview of international developments and how they impacted on the U.S. black market. For more on the 1931 convention as a watershed in international control efforts, see McAllister 2000, ch. 3. Global figures on the declining licit manufacture are found in "History of Heroin," 12.

13. William S. Burroughs, the "master addict" of his generation, was of the opinion that heroin was eight times as powerful as morphine (from letter to Allen Ginsberg in Burroughs 1993, 215).

14. In the 1920s decks reportedly sold for $1.00, $1.50, $2.00, $3.00, and $5.00 (New York State Commission on Prisons 1924).

15. Well before Pearl Harbor (December 1941), Anslinger had been stockpiling heroin as a strategic material, which drove up the price. The war itself brought tighter border controls, shipping disruptions, and travel restrictions. Seats on the remaining commercial airplanes, for example, were assigned on a priority basis to key government and military personnel. The term "VIP" was born of wartime flight rationing.

16. For more on postwar minority use and the federal laws of the 1950s, see Courtwright et al. 1989, 14–20; and Musto 1974, 230–32. The subject is also treated at length in the expanded edition of Courtwright 1982 (2001).

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